		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026328

Facility Name: Oakview Heights Continuous Care & Rehabilitation Center

Address: 1320 West Ninth St. (Number) Mt. Carmel (City) 62863 (Zip Code)

County: Wabash

Telephone Number: (618) 263-4337 **Fax #** (618) 262-7080

IDPA ID Number: 371104153001

Date of Initial License for Current Owners: 6/01/81

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501©(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Scott Cole, Administrator **Telephone Number:** (618)263-4337

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/01/02 to 08/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Scott Cole
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Jamie L. McCorkle, CPA
(Firm Name & Address) Wilcox & McGuire LTD, P.O. Box 340 Mt. Carmel, IL 62863
(Telephone) (618)262-5446 Fax # (618)262-8921

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 9/1/2002 Ending: 08/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 9/30/02

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	160	Skilled (SNF)	90	34,880	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	160	TOTALS	90	34,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,391	4,993	2,274	14,658	8
9	SNF/PED					9
10	ICF	9,900	5,453		15,353	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	17,291	10,446	2,274	30,011	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.04%

D. How many bed-hold days during this year were paid by Public Aid? 75 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2,274

Medicare Intermediary AdminaStar Federal (Indianapolis)

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 08/31/03 Fiscal Year: 08/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabil # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	200,190	32,726	7,681	240,597		240,597		240,597			1
2	Food Purchase		176,063		176,063		176,063	(9,238)	166,825			2
3	Housekeeping	119,772	16,382		136,154		136,154		136,154			3
4	Laundry	13,363	4,393	1,993	19,749		19,749		19,749			4
5	Heat and Other Utilities			104,042	104,042		104,042		104,042			5
6	Maintenance	53,212	22,199	39,804	115,215		115,215		115,215			6
7	Other (specify):*											7
8	**TOTAL General Services**	386,537	251,763	153,520	791,820		791,820	(9,238)	782,582			8
	B. Health Care and Programs											
9	Medical Director			10,460	10,460		10,460		10,460			9
10	Nursing and Medical Records	876,762	136,033	33,055	1,045,850		1,045,850		1,045,850			10
10a	Therapy	18,333	3,804	204,508	226,645		226,645		226,645			10a
11	Activities	30,265	1,230		31,495		31,495		31,495			11
12	Social Services	22,168		3,711	25,879		25,879		25,879			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	947,528	141,067	251,734	1,340,329		1,340,329		1,340,329			16
	C. General Administration											
17	Administrative	101,800			101,800		101,800		101,800			17
18	Directors Fees											18
19	Professional Services			37,919	37,919		37,919		37,919			19
20	Dues, Fees, Subscriptions & Promotions			8,407	8,407		8,407	(668)	7,739			20
21	Clerical & General Office Expenses	46,809	9,138	74,896	130,843		130,843		130,843			21
22	Employee Benefits & Payroll Taxes			193,020	193,020		193,020		193,020			22
23	Inservice Training & Education			3,086	3,086		3,086		3,086			23
24	Travel and Seminar			13,057	13,057		13,057	(402)	12,655			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			31,048	31,048		31,048		31,048			26
27	Other (specify):*			1,459	1,459		1,459	(1,459)				27
28	**TOTAL General Administration**	148,609	9,138	362,892	520,639		520,639	(2,529)	518,110			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,482,674	401,968	768,146	2,652,788		2,652,788	(11,767)	2,641,021			29

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center #0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			123,208	123,208		123,208		123,208			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,577	11,577		11,577	(56)	11,521			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,954	15,954		15,954		15,954			35
36	Other (specify):*											36
37	**TOTAL Ownership**			150,739	150,739		150,739	(56)	150,683			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			8,840	8,840		8,840		8,840			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,320	52,320		52,320		52,320			42
43	Other (specify):*			14,504	14,504		14,504	(14,504)				43
44	**TOTAL Special Cost Centers**			75,664	75,664		75,664	(14,504)	61,160			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,482,674	401,968	994,549	2,879,191		2,879,191	(26,327)	2,852,864			45

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Cent # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	9,238	2		4
5	Telephone, TV & Radio in Resident Rooms	1,459	27		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	56	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	14,504	43		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	668	20		28
29	Other-Attach Schedule Travel	402	24		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 26,327		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 26,327		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Oakview Heights Continuous Care & Rehabilitation Center

ID# 0026328

Report Period Beginning: 09/01/02

Ending: 08/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 **Report Period Beginning:** 09/01/02 **Ending:** 08/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	9,238	0	0	0	0	0	0	0	0	0	0	9,238	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	9,238	0	0	0	0	0	0	0	0	0	0	9,238	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	668	0	0	0	0	0	0	0	0	0	0	668	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	1,459	0	0	0	0	0	0	0	0	0	0	1,459	27
28	**TOTAL General Administration**	2,127	0	0	0	0	0	0	0	0	0	0	2,127	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	11,365	0	0	0	0	0	0	0	0	0	0	11,365	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center **#** 0026328 **Report Period Beginning:** 09/01/02 **Ending:** 08/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	56	0	0	0	0	0	0	0	0	0	0	56	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	56	0	0	0	0	0	0	0	0	0	0	56	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	14,504	0	0	0	0	0	0	0	0	0	0	14,504	43
44	**TOTAL Special Cost Centers**	14,504	0	0	0	0	0	0	0	0	0	0	14,504	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	25,925	0	0	0	0	0	0	0	0	0	0	25,925	45

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule of Board of Directors						
	None	N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V				$			$	$	1
2	V									2
3	V									3
4	V					N/A				4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehab # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4		N/A									4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Cente # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10				N/A						10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabil # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	United Leasing		X	Lease obligation	$475.00	8/24/98	$ 28,496	$	8/24/03	0.0850	$ 1,293	1
2	Gen'l Baptist-Campbell, MO	X		Mortgage	None	11/5/01	1,538,793	1,558,793	Demand			2
3												3
4												4
5												5
	Working Capital											
6	First Bank		X	Line of Credit	Various	11/05/02	250,000	185,452	11/5/03	0.0475	10,284	6
7												7
8												8
9	TOTAL Facility Related				$475.00		$ 1,817,289	$ 1,744,245			$ 11,577	9
	B. Non-Facility Related*											
10								Less: Interest income offset			(56)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (56)	14
15	TOTALS (line 9+line14)						$ 1,817,289	$ 1,744,245			$ 11,521	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center **#** 0026328 **Report Period Beginning:** 09/01/02 **Ending:** 08/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

No real estate taxes paid. Not-for-profit entity.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oakview Heights Continuous Care & Rehabilitation Center COUNTY Wabash

FACILITY IDPH LICENSE NUMBER 0026328

CONTACT PERSON REGARDING THIS REPORT Scott Cole, Administrator

TELEPHONE (618) 263-4337 FAX #: (618) 262-7080

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A - Not-for-profit entity		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 52,602 B. General Construction Type: Exterior Concrete/Sandstone Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Use	352,863	1981	$ 119,216	1
2	Resident Use	270,630	1994	60,000	2
3	TOTALS	623,493		$ 179,216	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1981	1981	$ 1,302,284	$ 46,920	30	$ 46,920	$	$ 1,032,252	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Roof			1982	16,721		7			16,721	10
11	Roof			1984	5,654		7			5,654	11
12	Additions			1985	9,569		7			9,569	12
13											13
14	Roof			1982	3,837		7			3,837	14
15	Building Imp.			1994	2,914	291	10	291		2,793	15
16	Roof			1996	68,042	2,268	30	2,268		16,065	16
17	Roof			1996	11,450	382	30	382		2,608	17
18	Walk in Freezer Units			1996	24,497	2,583	7	2,583		24,497	18
19	A/C Units			1996	7,686	1,098	7	1,098		7,320	19
20	Awnings			1997	8,300	553	15	553		3,240	20
21	Door Knobs/Locks			1997	3,448	493	7	493		2,955	21
22	Electrical-New Wiring			1997	23,632	945	25	945		5,514	22
23	Drywall			1997	21,125	1,408	15	1,408		7,981	23
24	Carpet			1998	7,927	1,132	7	1,132		5,851	24
25	Awnings			1998	3,694	528	7	528		2,771	25
26	Sign			1998	2,000	133	15	133		689	26
27	Wall Paper			1998	2,435	348	7	348		1,913	27
28	Plastic Coat: Roof-Wing 5			1998	12,500	417	30	417		2,292	28
29	12 Lavatory Faucets			1998	4,470	298	15	298		1,689	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38	9 Overhead Lights	1998	921	61	15	61		348	38
39	Exit Sign	1998	449	30	15	30		170	39
40	Chandeliers	1997	1,530	102	15	102		595	40
41	Other MG- Inc. Plumbing	1998	9,003	600	15	600		3,301	41
42	Exterior Sign	1998	3,200	213	15	213		1,049	42
43	Carpet,Curtains,Blinds	1998	11,249	1,125	10	1,125		5,531	43
44	Carpet,Curtains,Blinds	1998	19,656	1,966	10	1,966		9,664	44
45	Fuel Tank	1999	8,935	596	15	596		2,581	45
46	Wall Paper	1999	4,135	276	15	276		1,218	46
47	Kitchen	2000	4,231	423	10	423		1,445	47
48	Brittington Air & Water	2000	1,992	285	7	285		877	48
49	Building Handrails	2000	3,818	545	7	545		1,864	49
50	North-Side Heater	2001	6,090	870	7	870		2,247	50
51	Water Heater	2001	15,196	2,171	7	2,171		4,342	51
52	Tile- Wing 7	2000	3,753	536	7	536		1,433	52
53	Fire Doors	2000	4,861	486	10	486		1,337	53
54	Land Improvments	1982	14,363		10			14,363	54
55	Gazebo	1997	3,497	351	10	351		2,067	55
56	Parking Lot Repavement	1997	12,677	1,268	10	1,268		7,501	56
57	Landscaping	1997	8,837	589	15	589		3,338	57
58	Ditch Work	1997	700	47	15	47		276	58
59	Reseal Parking Lot	1999	3,336	667	5	667		2,891	59
60	Landscaping	1999	976	65	15	65		287	60
61	Land Improvments	2000	647	43	15	43		147	61
62	Land Improvments	2001	380	25	15	25		65	62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,686,615	$ 73,137		$ 73,137	$	$ 1,225,147	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 382,231	$ 47,654	$ 47,654	$	5-10 yrs.	$ 240,896	71
72	Current Year Purchases	13,142	457	457		5-10 yrs.	457	72
73	Fully Depreciated Assets	342,746					342,746	73
74								74
75	TOTALS	$ 738,119	$ 48,111	$ 48,111	$		$ 584,099	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1986 Mazda Truck	1992	$ 4,474	$	$	$	5	$ 4,474	76
77	Facility Use	1996 Chevy Van	1995	23,548				5	23,548	77
78	Facility Use	1998 Ford Pickup	2002	9,799	1,960	1,960		5	2,613	78
79										79
80	TOTALS			$ 37,821	$ 1,960	$ 1,960	$		$ 30,635	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,641,771	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,208	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,208	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,839,881	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87			N/A		87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93		N/A	93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Cente # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a : 2,3	hrs	$	3,685	$ 89,447	$ 562	3,685	$ 90,009	1
2	Licensed Speech and Language Development Therapist	10a : 3	hrs		635	29,477		635	29,477	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a : 2,3	hrs		3,122	85,584	3,242	3,122	88,826	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	7,442	$ 204,508	$ 3,804	7,442	$ 208,312	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 08/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 4,677	$ 4,677	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 300,000)	323,448	323,448	3
4	Supply Inventory (priced at)	38,142	38,142	4
5	Short-Term Investments			5
6	Prepaid Insurance	15,514	15,514	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 381,781	$ 381,781	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	179,216	179,216	13
14	Buildings, at Historical Cost	1,686,613	1,686,613	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	775,941	775,941	16
17	Accumulated Depreciation (book methods)	(1,839,881)	(1,839,881)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 801,889	$ 801,889	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,183,670	$ 1,183,670	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 147,652	$ 147,652	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	35,178	35,178	30
31	Accrued Taxes Payable (excluding real estate taxes)	11,420	11,420	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 194,250	$ 194,250	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,744,245	1,744,245	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,744,245	$ 1,744,245	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,938,495	$ 1,938,495	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (754,825)	$ (754,825)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,183,670	$ 1,183,670	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (578,020)	1
2	Restatements (describe):		2
3	**Rounding**	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (578,018)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(176,807)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (176,807)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (754,825)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitatio # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,658,333	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,658,333	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	8,983	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,983	23
	D. Non-Operating Revenue		
24	Contributions	6,082	24
25	Interest and Other Investment Income***	56	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,138	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Other	28,930	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 28,930	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,702,384	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	905,837	31
32	Health Care	1,464,922	32
33	General Administration	456,112	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	52,320	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,879,191	40
41	**Income before Income Taxes (line 30 minus line 40)****	(176,807)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (176,807)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,240	1,340	$ 27,299	$ 20.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,026	12,208	210,231	17.22	3
4	Licensed Practical Nurses	12,510	12,917	185,753	14.38	4
5	Nurse Aides & Orderlies	34,561	36,077	437,251	12.12	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,909	2,013	18,333	9.11	8
9	Activity Director	1,898	2,081	18,076	8.69	9
10	Activity Assistants	3,412	3,568	28,417	7.96	10
11	Social Service Workers	2,080	2,080	22,168	10.66	11
12	Dietician					12
13	Food Service Supervisor	2,048	2,088	26,603	12.74	13
14	Head Cook	7,927	8,598	59,088	6.87	14
15	Cook Helpers/Assistants	17,623	18,171	114,499	6.30	15
16	Dishwashers					16
17	Maintenance Workers	5,838	6,027	53,212	8.83	17
18	Housekeepers	18,675	19,498	119,772	6.14	18
19	Laundry	480	480	13,363	27.84	19
20	Administrator	1,960	2,080	54,189	26.05	20
21	Assistant Administrator	1,960	2,080	47,611	22.89	21
22	Other Administrative					22
23	Office Manager	2,000	2,080	18,011	8.66	23
24	Clerical	1,752	1,853	20,641	11.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Purchasing Agent	1,040	1,040	8,157	7.84	33
34	TOTAL (lines 1 - 33)	130,939	136,279	$ 1,482,674 *	$ 10.88	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	137	$ 7,681	1:3	35
36	Medical Director	Monthly.	10,460	9:3	36
37	Medical Records Consultant	72	340	10:3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	35	3,711	12:3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	244	$ 22,192		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	1,158	32,715	10:3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,158	$ 32,715		53

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott Cole	Administrator	N/A	$ 54,189
Gay Edmonds	Asst. Administrator	N/A	47,611
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 101,800

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Wilcox & McGuire	Accounting	$ 14,805
American Express Tax & Bus. Svc.	Accounting	14,634
Farrar Law Office	Legal	183
Health Care Systems	Computer	8,297
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 37,919

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 52,768
Unemployment Compensation Insurance	9,838
FICA Taxes	113,425
Employee Health Insurance	14,894
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	2,095
TOTAL (agree to Schedule V, line 22, col.8)	$ 193,020

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
	N/A	
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,250
Health Care Worker Background Check	
(Indicate # of checks performed 42)	526
Life Service Network of Illinois	3,828
Various Dues & Fees	2,603
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(668)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,739

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 402
In-State Travel	12,655
Seminar Expense	
	(402)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,655

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Cente # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4			N/A										
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oakview Heights Continuous Care & Rehabilitation Center # 0026328 Report Period Beginning: 09/01/02 Ending: 08/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of Illinois**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10:2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **52,320**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **9,238**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Wilcox & McGuire, CPA's** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Person Attending	Title	Date	Location	Title/Sponsor	Cost
G. Edmonds/ C. Fritchle	Asst. Adm	9/20/2002	Bloomington, IL	MDS/ RUGS W-shop	372.50
Kris Carroll	Diet Supr.	9/18/2002	Owensboro, KY		292.13
S. Cole/ G. Edmonds	Adm.	1/31/2003	Collinsville, IL	OCC/ AIL	222.55
G. Edmonds/ S.Cole	Adm.	7/20/2003	Flint, MI	Gen. Association	650.00
Scott Cole	Adm.	8/31/2003	Evansville, IN	Gen. Association	1,241.25
Various	Various			Employee Mileage Reimb.	10,278.57

Subtotal:	13,057.00
Less: Out of State Travel	(402.00)
Total:	12,655.00